

Horizon Family Medical Group

Review of Systems

Name _____

Date _____

Do you now or have you had any problems related to the following systems? **Please circle yes or no.**

<p>Constitutional Symptoms</p> <p>Fever Y N</p> <p>Chills.....Y N</p> <p>Headache.....Y N</p> <p>Unexplained Wt. Loss...Y N</p> <p>Wt. Gain.....Y N</p> <p>Problems sleeping.....Y N</p> <p>Other _____</p> <p>Endocrine</p> <p>Excessive thirst.....Y N</p> <p>Too hot / cold.....Y N</p> <p>Tired / sluggish.....Y N</p> <p>Other _____</p> <p>Eyes</p> <p>Blurred visionY N</p> <p>Double visionY N</p> <p>Eye painY N</p> <p>Other _____</p> <p>Ear/Nose/Throat</p> <p>Ear infection.....Y N</p> <p>Hearing loss.....Y N</p> <p>Sore throat.....Y N</p> <p>Sinus problems.....Y N</p> <p>Other _____</p> <p>Cardiovascular</p> <p>Chest pain.....Y N</p> <p>Varicose veins.....Y N</p> <p>High blood pressure.....Y N</p> <p>Fainting spells.....Y N</p> <p>Leg cramps when walking.....Y N</p> <p>Other _____</p> <p>Respiratory</p> <p>Shortness of breath.....Y N</p> <p>Wheezing.....Y N</p> <p>Frequent cough.....Y N</p> <p>Other _____</p>	<p>Gastrointestinal</p> <p>Abdominal pain.....Y N</p> <p>Nausea/vomiting.....Y N</p> <p>Indigestion/heartburn.....Y N</p> <p>Change in bowel habits.....Y N</p> <p>Rectal bleeding/black stools...Y N</p> <p>Other _____</p> <p>Genitourinary / Gyn</p> <p>Urinary frequency.....Y N</p> <p>Painful urination.....Y N</p> <p>Incontinence.....Y N</p> <p>Blood in urine.....Y N</p> <p>Impotence.....Y N</p> <p>Pelvic pain.....Y N</p> <p>Abnormal vaginal bleeding...Y N</p> <p>Abnormal discharge.....Y N</p> <p>#of pregnancies _____ #of live births _____</p> <p>Other _____</p> <p>Musculoskeletal / Neurological</p> <p>Joint pain / swelling.....Y N</p> <p>Neck pain.....Y N</p> <p>Back pain.....Y N</p> <p>Seizures.....Y N</p> <p>Numbness.....Y N</p> <p>Other _____</p> <p>Hematologic</p> <p>Swollen glands.....Y N</p> <p>Blood clotting problems.....Y N</p> <p>Other _____</p> <p>Allergic / Immunologic/ Skin</p> <p>Rash.....Y N</p> <p>Itching.....Y N</p> <p>Hay fever.....Y N</p> <p>Other _____</p> <p>Psychologic</p> <p>Do you feel depressed.....Y N</p> <p>Have you feel anxious/panic Y N</p> <p>Other _____</p>
---	---

Clinician's comments:

Clinician's initials /date of review
